Provider Task Force
Overview of 5 Proposals

	Better Health Care for Colorado	Solutions for a Healthy Colorado
What do we like about this proposal?	The phased-in approach can be a good way to expand coverage as it gives needed time to expand provider pools and time to test the impact on targeted groups. From the patient perspective the following elements are positive: choice; portability; waiving co-pays for healthy behavior; long term care and its housing components is good for the geriatric population; and first dollar coverage. From a business perspective expanding Medicaid to childless adults will bring healthy people in to the risk pool; and reimbursement at the Medicare fee scale is better than Medicaid reimbursement for private physicians. The residency approach would make it easier for those here legally to purchase insurance.	This proposal pulls in personal responsibility in a meaningful way with wellness and healthy life styles components. The plan explicitly addresses the cost shift cycle (although leaves out insurer component). Begins to address cost transparency in a meaningful way (needs to apply to all components). The "connector" component is a plus. Plans are required to offer at least a minimum core benefit package (essentially guaranteed issue). It is the only proposal that explicitly addresses medical malpractice. Establishes a deadline for HIT implementation. Realistic in acknowledging a long timeline for overall implementation of reform. Acknowledges provider reimbursement issues through proposed increased rates. The nutrition tax component of financing was attractive because it could help drive behavior change and affect obesity. It included at least some behavioral health coverage (not as much as other proposals). Uniform pricing model intriguing (but perhaps not workable.)
What concerns do we have about this proposal?	Costly plan covering the smallest number of currently uninsured. Reimbursements rates that disincentive provider participation will result in coverage in name only. A reliance on FFS payments is fundamentally flawed that does not reward outcomes and does support the "medical home" model. The benefit package is low with significant gaps. The $35K annual cap is too low for high utilizers, pushing some currently insured in to CoverColorado. The subsidy may not be sufficient and cause people to be disenrolled for non-payment, contributing to churn, interrupted care and cost shifting. Co-payments linked to income would be a constant hassle to calculate and could not be done at the doctor's office or hospital. Having the exchange side-by-side with public program administration creates the potential for confusion.	P4P only addressed for providers but not insurance plans. Employers don't appear to have enough "skin in the game" to remain in it. The $1,000 annual cap on DME and mental health is far too low. Medicaid-eligible recruitment scheme appears naïve (internet-based). Appears to be an imbalance in focus: too much on impact of medical malpractice (less than 1% of costs); far too little on administrative costs (20-30% of costs). Want to see proposal move beyond cliches and rhetoric to data and substance behind claims. Concern about short grace period before lack of premium payment sends individual back to ranks of uninsured and ED utilization. The proposal would be far more robust if it discussed regulation / rehab / responsibilities of insurance market. Need to focus healthy behavior incentives on evidence-based practices where results can be measured. Unrealistic and perhaps disingenuous to premise success on consumer decisons when most health care decisions are made by provider. Proposal makes false assumptions about numbers eligible for Medicaid.

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	A Plan for Covering Coloradans	Colorado Health Services Program
What do we like about this proposal?	Covers a large percentage of uninsured; expansion of Medicaid/CHP+; emphasis on Medicaid managed care; the Health Insurance Purchasing Authority facilitating clinical oversight; individual and employer mandates combined with guaranteed issue and community rating; coordination among payers allows for the opportunity to aggregate data; large purchasing pool spreading the risk; addresses a key cost-driver - chronic illness; disabled adults can buy-in up to 300% FPL; rewards good outcomes; administrative efficiencies through standardized forms, billing, payment systems; eliminates multi-step process for families; COBRA assistance; safety net explicitly included in the plan; inclusion of vision, dental, mental health, substance abuse, and hearing benefits for Medicaid; aligns incentives and rewards quality; individual responsibility; everyone has to give a little - spreads the "hurt"; realistically addresses difficuties of reducing costs; sets the stage for the necessary discussions about limits on inappropriate care, good stewardship etc	This plan covers all Coloradans through a single payer model operated as a public utility. Administrative simplification will save money and improve provider billing efficiency by reducing "hassle" created by different payers. There is a strong rural component that could help reduce / eliminate the rural / urban disparity by improving provider reimbursement thereby assisting in the recruitment and retention of rural providers. It recognizes regional differences through its governance structure. Coverage is comprehensive and includes primary care (including preventive and a medical home), mental health, and specialty care. It folds workers' comp into a single system of care. The proposal is attractive because it levels the playing field for business, eliminates for-profit shareholder costs, and is the only proposal that could cost less than the current system of care. It simplifies drug coverage. Presumptive eligibility for first two years covers everyone quickly. Consumers have choice of any provider. Providers are part of the governance structure.
What concerns do we have about this proposal?	Two reimbursement strategies were identified but Medicare option not modeled; workforce concerns to handle proposed Mediciad/CHP+ expansion; unsure the employer participation/crowd-out assessment is enough to keep employers in the game; perceived bias toward safety net; HIT ideas good but will take time and dollars to accomplish; provider tax may need to be modified and uncertainty as to whether it applies to hospitals only or physicians, too; sin taxes may incent healthy behavior but are regressive; assessment on the for-profit health plans may cause the to leave the state.	This is a "government" system with its incumbent concerns (will a huge bureaucracy be created / exacerbated?) Would eliminate the benefits of the market (e.g., innovation, technology development, competition, etc.) A single governance and operating structure could impede providers' abilities to negotiate for additional resources. As proposed there are no incentives to integrate practices (consider incentives to manage populations rather than only individual patients.) Concern that won't incent innovation and system efficiency. Concern that governing authority will not have will to make necessary tough tradeoffs in adopting newer, higher-cost medical advances. Access will be limited by capacity. Adverse selection could occur drawing sick people into Colorado. The governing authority appears very powerful; membership would be critical. Are chiropractors qualified to be PCPs?

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	5th Proposal
What do we like about this proposal?	Many of the positives of this proposal are also potential negatives (see below). Insurance market reforms are a plus, esp. guaranteed issue of basic plans, catastrophic coverage, end of life care (though eed to be willing to explicitly discuss trade-offs). Medicaid and CHP+ expansions are important, esp. dental benefits for adults. Individual mandate will likely increase number of people getting care, including prevention services which could avert important public health problems. Administrative simplification is a plus for providers and can reduce costs. Coordination of care/payment methodologies across physicians and hospitals, improved transitions across care settings. 24/7 nurse advice line. Coverage for undocumented people is a positive, as these patients are cared for ultimately anyway. Quality improvement: Explicit call for data aggregation is key. Tax credit for health IT would assist providers in automating their practices, as cost concerns are a major prohibitor. Voluntary continuous coverage allows for some experimentation with single payor. Expanded APN scope of pract
What concerns do we have about this proposal?	Changing Medicaid to CHP+-like benefits will be a reduction for some, despite additions (e.g., dental). 3-4 basic plans may be underinsurance for many. Infrastructure components (case managers, 24/7 nurse help line, connector, data aggregation, quality improvement) are good things, but may not create a return on investment short-term. Without clear limits on care, costs may continue to rise unabated until programs take effect. Does not go far enough in admin simplification; workforce development; recruitment/retention; end-of-life care; risk-adjusted payments; public health, incl. nutritional education and the narrow definition of safety net providers; telemedicine; defining, measuring, and rewarding high quality care. APNs as primary providers controversial - questions of regulatory oversight and payment parity. Medicaid reimbursement as proposed is insufficient to attract enough private providers back. IT infrastructure, provider tax may raise costs for providers. Providers don't want to be used as an instrument of state immigration policy. CoverColo expansion, catastrophic coverage